

LIGHTWOOD

DENTALCARE

## Consent to dental treatment during COVID-19

I am aware that the current COVID-19 pandemic brings a number of known risks and a number of unknown risks. I have chosen to seek dental treatment during the pandemic in the knowledge that much is still unknown about the virus.

I understand the coronavirus that causes COVID-19 has a long incubation period during which time carriers of the virus may not show symptoms yet still be highly infectious. I also understand that some people may have the virus but may not ever have any symptoms. I therefore understand it is impossible to determine who has the virus and I understand that I must assume that anyone anywhere could be infected and infectious \_\_\_\_\_ Initial

I confirm that I am not currently suffering from any of the following symptoms of Covid-19 and I have not suffered from any of these symptoms in the last 10 days \_\_\_\_\_ Initial

[Fever \(a temperature of 37.8 degrees centigrade or above\).](#)

A new persistent dry cough.

Muscle pains.

Headache.

Shortness of breath and breathing difficulties.

Severe pneumonia.

Loss of taste and/or smell.

Extreme fatigue.

Runny nose.

Sore throat

I confirm that I have not been in close contact (within 2 metres) of anyone suffering with any of these symptoms in the last 14 days \_\_\_\_\_ Initial

I understand that receiving dental treatment means that the UK government's instruction to maintain social distancing of at least 2 metres is not achievable during dental treatment \_\_\_\_\_ Initial

If you have tested positive for COVID 19 in the last 3 months, please initial to confirm that you are not suffering with the following symptoms:-

Fever (a temperature of 37.8 degrees centigrade or above).

Sneezing/runny nose

Nausea/diarrhoea

\_\_\_\_\_ Initial

I understand that some people are considered to be at greater risk of serious illness or higher mortality if they contract COVID-19 and I understand that these are individuals who:

Have pre-existing medical conditions such as heart and circulatory disease.

Have high blood pressure.

Have diabetes.

Are very overweight.

Are male.

Are over 60 years of age.

Are from a black, Asian or minority ethnic (BAME) background.

\_\_\_\_\_ Initial

I understand that Dr. Cowan/Dr. Austin will take every precaution to make sure my treatment is provided according to strict clinical protocols and hygiene procedures \_\_\_\_\_ Initial

I consent to the treatment being provided during the current phase of Covid-19.

Name \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_